

MONTANA BREAST AND CERVICAL HEALTH PROGRAM

[illegible]

CLIENT RECORD REVIEW
(Used by MBCHP staff during review)

Note: Use one review sheet for each record/clerk reviewed. Place an X in the blank to indicate item located on client record. Place an O in the blank to indicate item not located on client record. Place an NA if the item does not apply.

1. ____ Client name _____ Date of Birth _____ ID# _____
____ Current address _____
2. ____ Documentation and date of financial eligibility
3. ____ Informed Consent and Authorization to Disclose Health Care Information form (which acknowledges client participation in MBCHP signed, dated and witnessed)
4. ____ Pap test results recorded and filed correctly
____ Appropriate follow-up and documentation for abnormal test results
5. ____ All screening mammography results are recorded and filed correctly
____ Appropriate follow-up and documentation for abnormal test results
6. ____ Current Pap, pelvic, CBE documented and current
____ SBE taught and documented
7. ____ Copies of all necessary MBCHP data collection forms
8. ____ Quality Assurance Review:
 - a. Pap
____ Screening to final diagnosis <60 days
____ Final diagnosis to treatment <60 days

Referred to: _____ Documentation back from referral source: _____

Date: _____ Yes ____ No ____ Date: _____

- b. Breast
____ Screening to final diagnosis <60 days
____ Final diagnosis to treatment <60 days

Referred to: _____ Documentation back from referral source: _____

Date: _____ Yes ____ No ____ Date: _____

Comments: